Special Process for Tetanus Vaccine Claims Submitted before July

We’ve developed a special temporary process for providers to resubmit claims for the new tetanus vaccine DECAVAC (CPT procedure code 90714). Because the CPT code was not effective until July 1, 2005, our claims systems rejected those that were submitted earlier. We had hoped to be able to accept these claims before July, but it was not possible.

To ensure that your resubmitted claim will not be denied for timely filing, please submit the claim on paper. Attach the special Tetanus Vaccine Resubmittal form (included in this newsletter) to the front of the claim. Mail completed form and claims to the address below:

Excellus BlueCross BlueShield, Central New York Region
RTR Department
PO Box 4809
Syracuse, NY 13221

If you previously submitted a claim for DECAVAC and used an unlisted vaccine code, you may submit the claim for adjustment using our Request for Adjustment form. Do not use the Request for Adjustment form, however, if you submitted a claim for 90714 that denied as an invalid code.

Please note that many of our health benefit programs do not cover adult immunizations. It is important to verify eligibility before providing service. If it is not a covered benefit, you must collect payment directly from the patient.

Thank You for Your Support During Our Annual Data Collection!

Our Quality Management Department wishes to sincerely thank all the physicians and office staff who participated in our 2005 annual data collection process.

The previous year data we collect is for the Health Plan Employer Data and Information Set (HEDIS) and Quality Assurance Reporting Requirements (QARR). The National Committee for Quality Assurance (NCQA) and the New York State Department of Health (DOH) require us to report specific measurements annually.

We’ll be publishing results in a future issue of this newsletter, after the data are compiled and audited.

Analysis of the data collected allows us to evaluate performance levels for primary and preventive care, and to determine future quality improvement initiatives. It also helps pinpoint our strengths and weaknesses.

We appreciate all the time and effort given to assist us!
You asked Provider Service the question…

...we publish the answer–For Everyone!

Q. I’d like to learn how to use the new Web features. Whom can I contact for training?

A. Your Provider Relations Representative would be happy to set up an appointment for Web training. Please refer to the June *Just the Facts*, or the Web site (see below) for the most recent list of contact information. You can also contact us; we’ll pass the information to your Provider Relations Representative and he/she will call you back to set up the appointment.

As a reminder, we’ve also included a list of the new Web features that are available. Just turn to the Connectivity Page located in the middle of this newsletter.

Don’t forget—*Just the Facts* and the 2005 *Participating Provider Manuals* are on our Web site!

### Just the Facts

Provider newsletters for the past two years are available at www.excellusbcbs.com!

- Click on *For Providers*.
- Go to the bottom of the page and click on *News and Updates*.
- Look under *Provider Newsletters*.
- Select *Just the Facts* for your region.

Select the month’s issue you would like to read.

### 2005 Participating Provider Manual

Provider Manuals, which are regularly updated, are available at www.excellusbcbs.com!

- Click on *For Providers*.
- Click on *Administration* at the top of the page.
- Click on *Provider Manuals* in the left column.
- The options for the regional manuals will appear under the *Provider Manual* heading; select the region you need.

*If you do not have access to the internet and need a paper copy of the Provider Manual, please contact Provider Service.*

Extra, Extra! Provider Forms are located at www.excellusbcbs.com!

Just go to www.excellusbcbs.com, select *For Providers* and click on *Print Forms* at the bottom of the page.

You’ll find forms for:

- Administration
- Ancillary Services
- Benefits Management
- Billing and Remittance
- Pharmacy Management
- Provider Contact Lists (includes a list of your Provider Relations Reps!)
- Quality Management

AND…

...You can even order preprinted patient brochures and supplies!
BlueCard Claims and Member Information Updated at the Home Plan

When a BlueCard claim is denied for Coordination of Benefits (COB) and/or membership eligibility (e.g., ineligible dependent and/or cancelled coverage), and the home plan (e.g., Empire BlueCross BlueShield) confirms that the missing information has been updated, you do not need to contact us for a claim adjustment. The home plan will initiate a claim adjustment and send us that information. This will help to expedite the reprocessing of these claims and decrease the volume of outbound calls your office is experiencing.

If you have questions about this process, please contact Provider Service.

ClaimCheck Status and Future Update

The recent update to our electronic clinical editing software was designed to provide a solid foundation for future clinical editing. A number of providers brought to our attention issues that came up as part of the transition. We are now actively addressing these issues. We are also preparing to update to the newest version of ClaimCheck.

We want to thank those providers who have brought issues to our attention. In addition, we would like to thank you for your patience as we improve our technology and our processes.

Formal Billing Inquiries

We do appreciate that there are instances where you disagree with clinical editing determinations for a procedure code combination. Examples of these edits are incidental services, mutually exclusive and rebundling. We are working out a process that will make it easier for you to bring these issues forward.

In the meantime, please continue to use the current process. That is, write out your concerns and include supporting documentation with clinical rationale. If you are questioning our general methodology on a specific coding scenario, please state this. Do not send medical records. We will request them if needed. However, if your question is about a specific member's case, we may need the specific medical records in order to make a determination. You may send these review requests to the attention of Clinical Editing Review.

Please remember, it is very important to use modifiers appropriately per standard coding guidelines. If a modifier is used with a code for which it is not appropriate, the claim will deny for invalid procedure modifier combination. Appropriate modifiers are listed in both the CPT and HCPCS manuals. (See related article about appropriate use of modifiers.)

Next update planned for October

We plan to update our version of ClaimCheck in October to bring the edits up to date for 2005. This is mostly a routine update. ClaimCheck software is updated regularly to:

- Add any necessary edits related to new CPT codes
- Modify edits where CPT language has been revised
- Remove edits that refer to deleted CPT codes

Clinical and operational personnel review the edit revisions to ensure the changes are consistent with our reimbursement and coverage policies. Our review of the upcoming 2005 release indicates that, in addition to the updates listed above, there are also several additional new edits not directly related to the added, deleted or revised CPT codes. These edits are summarized in the table on the following page.
2005 ClaimCheck Edits other than New, Revised and Deleted CPT Procedure Codes

<table>
<thead>
<tr>
<th>CPT Procedure Code</th>
<th>Used with CPT Procedure Codes</th>
<th>How ClaimCheck edit will process</th>
</tr>
</thead>
<tbody>
<tr>
<td>01958</td>
<td>01961</td>
<td>ClaimCheck will consider 01958 mutually exclusive to 01961.</td>
</tr>
<tr>
<td>76986</td>
<td>59070, 59072, 59074, 59076</td>
<td>ClaimCheck will consider 76986 incidental to 59070, 59072, 59074, and 59076.</td>
</tr>
<tr>
<td>62284</td>
<td>62284</td>
<td>ClaimCheck will recommend reimbursement for only one submission of procedure 62284.</td>
</tr>
<tr>
<td>35206, 35236, 35266, 35500, 35512</td>
<td>35510</td>
<td>ClaimCheck will consider 35206, 35236, 35266, 35500, and 35512 incidental to 35510.</td>
</tr>
<tr>
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<td>35512</td>
<td>ClaimCheck will consider 35206, 35236, 35266, 35500, and 35522 incidental to 35512.</td>
</tr>
<tr>
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<td>35522</td>
<td>ClaimCheck will consider 35206, 35236, 35266, and 35500 incidental to 35522.</td>
</tr>
<tr>
<td>35522</td>
<td>35512</td>
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</tr>
<tr>
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<td>35525</td>
<td>ClaimCheck will consider 35206, 35236, 35266, 35500, 35512, and 35522 incidental to 35525.</td>
</tr>
</tbody>
</table>

Excellus BCBS Receives National Recognition for “Step Up” Program

The Excellus BlueCross BlueShield (Excellus BCBS) Step Up program recently received national recognition from the BlueCross BlueShield Association. Step Up, which began last summer, is designed to help combat the problem of obesity in the community - and people seem to be responding to it! Currently, over 200 employer groups have requested Step Up tool kits, and the Step Up Web site has received more than 12 million hits.

If you’d like more information about the Step Up program, and the tools that are available for you and your patients, please visit www.stepup.excellusbcbs.com. Select Providers at the top of the page and see what “stepping up” can do for you and your patients!

HMOBlue 25 Benefit Change for 2006

Effective January 1, 2006, the HMOBlue 25 (prefix ZFC) benefit for both prenatal and postnatal visits will change from a $25.00 copay for each of the first 10 visits, to $5.00 for each of the first 10 visits. After the first 10 visits, the remainder will be covered in full. Please note that both prenatal and postnatal visits are only covered when the member goes to an “in-network” provider. There is no out-of-network coverage.
Save the Date: Fall into Coding 2005 – September 15, 2005

Save the date (Sept. 15) for this second annual seminar, sponsored by the Upstate New York Chapter of the American Academy of Professional Coders (AAPC). The seminar will be from 8:00 a.m. to 4:45 p.m. at the Radisson Hotel in downtown Utica. **The Chapter is requesting eight continuing education units (8 CEUs)** for attendance at this conference. Scheduled speakers are as follows:

- Frank Dubeck, MD, Regional Vice President and Chief Medical Officer for Excellus BlueCross BlueShield, Utica Region, will provide opening remarks.
- Terence Johnson, JD, CPC, CCP and Vice President of CPC Solutions, Inc., a Chicago consulting firm, will address compliance issues and health care regulatory concerns. Mr. Johnson is also the author of the monthly legal advisory committee’s article “Viewpoint” in the AAPC publication Coding Edge.
- Hazel Miller, LPN, CPC, and Senior Professional Representative for Empire Medicare, will present two 45-minute sessions to cover Medicare Part A coding, Modifier 25 with E&M coding, and CERT (Comprehensive Error Rate Testing).
- Cindy Hummel, Regional President for Excellus BlueCross BlueShield, Utica Region, will speak on current legislative issues affecting the health care industry.
- Donna Silsbee, PhD, RHIA, CTR, CCS and professor at SUNY Institute of Technology in Utica will explain how to be prepared for the changes from ICD-9 coding to ICD-10 and how these new codes will be structured.
- Flora Allen, Director of Special Investigations for Excellus BlueCross BlueShield, will speak on ‘real life’ coding issues, fraud investigation, and resolution and recovery scenarios.
- Terry Leone, CPC, CIC, CMBS and President of Catamount Associates, will address a multitude of radiology coding issues. Mr. Leone looks forward to challenging questions from the audience.
- Chuck Spinelli, President of Spinelli Consulting, will address Internet crime and health care.

Registration is $99.00 and includes all seminar materials as well as a continental breakfast, lunch and afternoon refreshments. Vendors will also be on hand to provide educational and technical information related to the health care industry.

Look for pre-registration information on the Upstate New York Chapter of the AAPC Web site at [http://uticanewyork.lc.aapc.com](http://uticanewyork.lc.aapc.com).

**Excellus BCBS to Discontinue MSA Blue/MSA Advantage**

When President Bush passed the Medicare Modernization Act of 2003, he also introduced a new way of saving money for retirement – Health Savings Accounts (HSAs). Since their introduction, our products that provided members with the advantages of a Medical Saving Account (MSA), became obsolete. In an effort to respond to the needs of our members, we have created new products that support this legislation (e.g., BluePPO HSA). Therefore, we have decided to discontinue MSA Blue/MSA Blue Advantage (prefix YME), effective January 1, 2006. Our members and groups are being notified and encouraged to look into our BluePPO HSA product; a product within which, members are eligible to open a health savings account.
Coding Corner

Appropriate use of modifiers

Appropriate use of modifiers can actually help your claims process more accurately and quickly. Modifiers can clarify how a HCPCS or CPT procedure code is used. For example, if something is done bilaterally and there is not a specific code for that bilateral procedure, using CPT modifier 50 tells the claims processing system that it was bilateral. Submitting two lines of the same code may only cause one to deny as a duplicate.

Inappropriate use of modifiers can also cause claims to deny. For example, CPT modifier 26 is to add a professional component to a CPT procedure code. If used with a CPT code that is already only a professional component, or that includes a professional component, it will cause the claim to deny.

An example of this is the use of modifier 26 with CPT procedure code 93010. This code is for interpretation and report only. It already codes just the professional component. In other words, there is no global code for this. Therefore, it is not appropriate to attach modifier 26. The use of the 26 modifier with 93010 will cause the claim to deny.

Appropriate modifiers are listed in both the CPT and HCPCS manuals, and defined in a separate appendix in each manual. Additional resources on coding standards are also publicly available, including such publications as “Understanding Modifiers,” published by Ingenix.

NYS Requires Health Plans to Cease Payment on Erectile Dysfunction Medication for Select Excellus BCBS Products

Effective immediately, Excellus BlueCross BlueShield (Excellus BCBS) has been directed by both the New York State Insurance Department and the Department of Health to stop payment of claims for erectile dysfunction medication for the following:

- All Healthy New York members
- All direct pay subscribers under HMO and POS contracts
- All Family Health Plus members (This suspension will remain in effect for 120 days and will therefore expire on September 24, 2005.)
- All Child Health Plus claims (unless the medication is prescribed to treat conditions other than erectile dysfunction)

This suspension will remain in effect until further notice. Please continue to watch future communications for updates.
**Update: Meningococcal Vaccine Policy**

The Excellus BlueCross BlueShield Medical Policy related to meningococcal vaccines has been updated. The updated policy considers meningococcal vaccine *medically appropriate* for the following groups of people, based upon the recommendations of The Centers for Disease Control’s Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics:

- Persons exposed to a community or organization-based outbreak of meningococcal disease or serogroup C meningococcal disease (SCMD);
- Persons who have certain medical conditions that place them at increased risk for developing meningococcal disease, including persons who have terminal complement component deficiencies and persons with functional or anatomic asplenia (e.g., sickle cell disease, or splenectomy);
- Young adolescents (11-12 years of age old);
- Adolescents at high school entry or 15 years of age (whichever comes first) for those who have not previously been vaccinated; or
- College freshmen living in dormitories.

Please note: conjugated meningitis vaccine (Menactra™, Aventis Pasteur) is the preferred vaccine for persons 11–55 years of age in the above risk groups, but MPSV4 (Menomune) can be used if MCV4 (Menactra) is not available.

These vaccines will now be covered based upon the updated Medical Policy criteria for any subscriber who has well child benefits. Please use CPT code 90734 when billing for the meningococcal conjugate vaccine (Menactra) (serogroups A, C, Y and W-135/tetravalent). CPT code 90733 should be used when billing for the meningococcal polysaccharide vaccine (Menomune) (any group). We will pay administrative fees according to the provider’s fee schedule and member contract. For more information, please refer to the June Provider Bulletin ([#13-05][2005-12]) that was mailed to participating primary care physicians, and/or the Medical Policy within this newsletter. If you need more information, but did not receive a copy of this notice, please contact Provider Service.

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**Don’t Forget to Obtain Prior Authorization**

It is important to note that if prior authorization is not obtained when required, and the service is provided anyway, the claim may deny or pay at a lower level based on the terms of the member’s contract. For most HMO members, if the provider fails to follow our UM guidelines, the claim is denied and the member is held harmless. In other words, the provider may not bill the member, except for appropriate cost-sharing amounts such as copays. Point-of-service member claims will pay, but at a lower level (out of network) of benefit, when required preauthorization is not obtained. In this case, the provider may bill the member for the remainder, up to our allowance. This also applies to PPO products, where we apply an additional penalty for which the member is responsible. The provider will have to collect this amount from the patient. Please refer to the Prior Authorization Requirements Comparison chart included in this newsletter. You must obtain prior authorization for any service listed as requiring it, regardless of site of service (including in-office procedures).
Report on 2004 Surveys of Behavioral Health Practitioners

Regulatory and accreditation agencies require that we track and trend certain information about service to our managed care members, including appointment availability and whether specialists (including behavioral health specialists) share information about their patients with the primary care physician (continuity of care). For behavioral health (BH) services, the New York State Department of Health requires that there be a signed consent (i.e., Authorization for Release of Information) in the patient’s record from the patient or the patient’s guardian.

2004 Behavioral Health Continuity of Care Survey

Continuity of care is subject to annual review for the entire managed care population, including Medicaid and Medicare Advantage members. In 2004, 87 BH practitioners participating with Excellus BlueCross BlueShield, Central New York Region, Central New York Southern Tier Region, and Utica Region met criteria requiring a continuity of care survey.

Review

Continuity of care is measured during the Treatment Record Review (TRR) and/or a self-reported mail survey. Both measure whether the BH specialist exchanges information about their patients with the PCP and other practitioners as necessary, and whether or not a consent form for ‘Release of Information’ was obtained for each practitioner.

Overall performance threshold for these measurements is 85 percent.

Results

The 2004 aggregate compliance rate for exchanging information with the PCP was only 69.6 percent, but represented a significant increase over 57.5 percent in 2003. The exchange with other BH providers and practitioners as necessary exceeded the goal at 87 percent. However, only 81 percent were compliant with obtaining a written consent for ‘Release of Information’ for these exchanges of information.

Barriers to compliance

The exchange of information with the PCP is assessed for timeliness, frequency and content of communication. There were two prevalent barriers identified to the overall compliance:

1. Lack of understanding about managed care and the importance of PCP coordination of the patient’s care, unless it appeared to be warranted for a medication evaluation, change, or other medical concerns addressed during therapy.

2. The majority of BH practitioners not in compliance with the requirement for obtaining a written consent for ‘Release of Information’ were unaware this is a New York State Department of Health requirement which supersedes the less stringent HIPAA.

Follow-up

The wrap-up, immediately following the TRR, addresses weaknesses in documentation and includes continuity of care. Practitioners are given a copy of tools such as a Communication Log and a Collateral Contact Sheet. These tools are part of the optional packet of record-keeping forms provided to the practitioner as necessary. They are available on the Excellus BlueCross BlueShield Web site at www.excellusbcbs.com/providers/patient_care/behavioral_health.shtml.

The follow-up cover letter, generated by the TRR scoring software and sent out with each practitioner’s score sheet, also stresses the importance of Continuity of Care with the PCP as well as the required written consent for release of information to the PCP.

The BH Continuity and Coordination of Care policy is also available on the Web site at www.excellusbcbs.com/download/files/bhqi-9.2.pdf. This document, and others noted above, are also available by mail. Please contact James Riter, Excellus BlueCross BlueShield, Central New York Region, 344 South Warren St., Syracuse, NY 13202.
2004 Behavioral Health Appointment Availability Survey

Our behavioral health (BH) staff reviewed appointment availability with the same 87 behavioral health practitioners and groups who met criteria for a Treatment Record Review (TRR) or the continuity of care survey. Our Behavioral Health Access and Availability Standards are relevant for the entire managed care population, including Medicaid and Medicare Advantage members. We perform this survey annually.

The Behavioral Health Quality Committee considers BH practitioners compliant if the requirements for urgent and routine care are met for at least 85 percent of the applicable population or if at least 85 percent of the applicable population indicate that they are satisfied with their access to urgent and routine care.

During each onsite survey, BH staff presented examples of an urgent and a routine care appointment request by established patients and asked how soon those patients would be seen. Responses in compliance were:

1) urgent care appointment within 48 hours, and
2) routine care appointment within 10 business days (14 calendar days).

(continued from page 9)

The BH practitioners surveyed were 96.6 percent compliant for urgent care access and 93.1 percent compliant for routine care appointment access.

Examples of urgent, emergent and routine appointment situations are included in the Health Plan’s Behavioral Health Access and Availability Standards policy, available on our Web site at https://www.excellusbcbs.com/download/files/bhqi-1.pdf, by mail from Jim Riter, Excellus BlueCross BlueShield, Central New York Region, 344 South Warren St., Syracuse, NY 13202, or by calling Provider Service.

2005 Behavioral Health After Hours Access and Availability

The Health Plan’s Behavioral Health (BH) Access and Availability Standard states that telephone access to behavioral health practitioners for urgent/emergent care for the practitioner’s established patients should be available on a 24-hour, seven day-a-week basis.

Compliance rate

The BH After Hours Survey/Audit was developed to check the compliance of BH practitioners in our managed care network. The goal is an average compliance rate of 85 percent across all BH specialties.

In 2005, we surveyed over 800 BH practitioners. The compliance rate for the combined regions of Central New York, Central New York Southern Tier, and Utica was 91.1 percent, a one percentage point increase from 2004. Excellus BCBS and the Behavioral Health department wish to express our gratitude for the attention the BH practitioners have given to better serving and caring for our members.

Three options for after hours access

The three answering options that were considered in compliance for the After Hours Audit were as follows:

1. Reaching the practitioner or a person with the ability to patch the call through to the practitioner (i.e., answering service), or
2. Reaching an answering machine with instructions on how to contact the practitioner or his/her backup (i.e., message with number for home, cell phone, or beeper), or

(continued)
3. Reaching an answering machine with instructions to call a Crisis Center/CPEP or Lifeline.

The first two answering options above are certainly the preferred choices. The third option is available to BH practitioners participating with Excellus BCBS in the Central New York, CNY Southern Tier, and Utica Regions, where there may be cell phone or beeper signal drop-out.

The third option is considered compliant only when the practitioner has an agreement with the Crisis Center/CPEP or Crisis Line, whose number is given on the answering machine. The agreement must stipulate that the Crisis Center/CPEP or Crisis Line has the BH practitioner's current phone, cell, or beeper number, and that the organization will first make an attempt to reach the member's actively-treating BH practitioner for triage purposes, and/or notify the practitioner as soon as possible concerning the phone contact or visit made with the member.

Seventy-two offices out of compliance

Seventy-two private BH offices had telephone messages that were not in compliance with the above. Sixty-three were out of compliance for the first time. Nine were out of compliance for the second consecutive time. Behavioral Health staff is following up with letters to all practitioners that were surveyed.

Standards and policies available on Web site

The Behavioral Health After Hours Access and Availability Standards and other BH policies are available on the Health Plan’s Web site at https://www.excellusbcbs.com/providers/patient_care/behavioral_health.shtml.

For additional information about the Behavioral Health Quality Program, please call BH Quality Management at (315) 671-7043. To update information, such as address or telephone number, please complete a Provider Information Update Form, available on our Web site or from Provider Service.

Medical Policy/Protocol Update

To ensure that the development of corporate medical policies occurs through an open, collaborative process, we encourage our participating practitioners to become actively involved in medical policy development. Each month, draft policies are posted in the Provider section of our Web site (www.excellusbcbs.com) for participating practitioners' review and comment. Click on For Providers, then Medical Policies. Next, click on Preview & Comment on Draft Policies located at the bottom of the menu on the left side under Medical Policies. The following policies are tentatively scheduled to be available for comment in July 2005:

- Cardiac Disease Risk- Laboratory Evaluation (new)
- Cytochrome p450 (new)
- Fecal DNA Testing (new)
- Intrastralomal Corneal Ring Segments (new)
- MAZE Procedure
- Sleep Studies
- Stereotactic Radiosurgery and Fractionated Radiosurgery

Corporate medical policies are used as a guide. Coverage decisions are made on a case-by-case basis and in accordance with the member's contract. While a technology or service may be medically necessary, payment of benefits is subject to the member's eligibility on the date the service is rendered and the benefit/exclusion provisions in the member's contract. (continued)
Before rendering care, providers should verify the member's eligibility for the service by calling the Provider Service Department of your local plan.

The following new and updated medical policies have been reviewed and approved by the Corporate Medical Policy Committee, including practitioner representatives from Excellus BlueCross BlueShield, Central New York Region, Central New York Southern Tier Region, Utica Region, and Rochester Region.

Complete detailed policies are available on our Web site at www.excellusbcbs.com. Click on the For Providers menu option, then on View Our Medical Policies. Questions regarding medical policies may be directed to your Provider Relations Representative or to the Provider Service Department of your local health plan.

Medical policies are also located on the Web site for Excellus BlueCross BlueShield members at www.excellusbcbs.com. To access our policies, members need to click on For Members, followed by Health and Wellness, then Research Health Conditions and lastly View our Medical Policies.

Policies and protocols referenced in this newsletter are written for commercial contracts only. A brief description of CMS coverage has been provided for some Excellus BlueCross BlueShield medical policies that differ from CMS. Please refer to the Centers for Medicare & Medicaid Services (CMS) for medical policies pertaining to Medicare contracts. Web sites for review of CMS policies are:

- www.umd.nycpic.com/lmrp.html for local Upstate New York Medicare policies

Please note: Although medical policies are effective on the date they are approved by the Medical Policy Committee, updates to the claims processing systems may not occur for up to 90 days in order to allow you to update your billing systems accordingly.

**NEW POLICIES recently approved by Corporate Medical Policy Committee**

**Angiogenic Inhibitors for the Treatment of Exudative Age-related Macular Degeneration** are medications, that when administered, block new vessel growth or neovascularization. An intravitreal injection regimen of pegaptanib sodium or Macugen®, currently the only FDA approved anti-angiogenic medication, is considered medically appropriate for patients with neovascular age-related macular degeneration when the visual acuity in the affected eye is 20/40 to 20/320 and the lesion size is less than or equal to 12 disc areas. Macugen® must be administered by an ophthalmologist who has completed a fellowship in vitreoretinal diseases and surgery.

Although there is no specific national or local Medicare coverage determination addressing Macugen®, there are coding and reimbursement guidelines with coverage being provided under Medicare Part B, Drugs and Biologicals.

**CURRENT POLICIES recently updated by Corporate Medical Policy Committee**

**Meningococcal Vaccine** is medically appropriate for the following groups of people, based upon the recommendations of the Center for Disease Control Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP):

- Young adolescents (11-12 years of age);
- Adolescents at high school entry or 15 years of age (whichever comes first) for those who have not previously been vaccinated;
- All college freshmen living in dormitories;

(continued)
Those exposed to an outbreak (community or organization-based) of meningococcal disease or serogroup C meningococcal disease (SCMD);

Those who have certain medical conditions that place them at increased risk for developing meningococcal disease including persons who have terminal complement component deficiencies and persons with functional or anatomic asplenia (e.g. sickle cell disease, or splenectomy).

While no specific national or local coverage determination was found addressing meningococcal vaccine, CMS coverage would be provided if the patient had direct exposure to the associated disease and if there was significant risk that the patient could contract the disease as a result of the exposure.

Endometrial Ablation is a method of treating menorrhagia through the destruction of the endometrial lining. Endometrial ablation, performed with FDA approved devices, is a medically appropriate treatment option for premenopausal women for whom childbearing is complete and symptoms are severe enough to warrant surgical intervention. Specific criteria that must be met are outlined with the medical policy.

There is no national or local Medicare coverage determination addressing endometrial ablation.

Endovascular Grafts for Abdominal Aortic Aneurysms (AAA) and Thoracic Aneurysms have been investigated as less invasive, catheter-based alternatives to open surgical excision of thoracic and abdominal aortic aneurysms.

- Patients with aneurysms measuring 5 cm or greater in diameter;
- Women or small individuals with an AAA measuring twice the diameter of the normal aorta at the infrarenal neck; or
- Individuals with an enlarging AAA, which is symptomatic or greater than 4 cm in size and has increased in size in the last 6 months.

Placement of endovascular grafts is considered investigational:

- In patients with a leaking or suspected ruptured AAA;
- A previous AAA repair or tortuosity of access vessels; or
- In patients with a thoracic aortic aneurysm.
- There is no national or local Medicare coverage determination addressing endovascular grafts.

Genetic Testing for Specific Diseases is considered medically appropriate when the following situations exist:

- Offered in a setting with adequately trained health care professionals to provide appropriate pre- and post-test counseling and performed by a qualified laboratory;
- The patient’s family history indicates a significant risk for a genetic defect for which therapeutic measures, instituted as a result of knowledge of a particular defect, can prevent or mitigate future morbidity; or
- Symptomatic patients who may have genetic disease or asymptomatic individuals who may have genetic disease or strong family history of genetic disease where early diagnosis is important;
- There must be reasonable expectation based on family history, pedigree analysis, risk factors, and/or symptomatology that a genetically inherited condition exists. Autosomal recessive disorders may be present without a family history;
- The genotypes to be detected by a genetic test must be shown by scientifically valid methods to be associated with the occurrence of the disease, and the analytical and clinical validity of the test must be established;
The clinical utility of the test must be established, i.e. test results will influence decisions concerning disease treatment or prevention. This policy is to be utilized ONLY when disease or condition-specific policies for genetic testing do not exist.

There is no national or local Medicare coverage determination addressing genetic testing.

**Radiofrequency Tumor Ablation** causes in situ cell destruction by thermal coagulation and protein denaturation. Radiofrequency ablation of hepatic lesions (primary and metastatic) is considered a medically appropriate treatment option for selected patients under ALL of the following conditions:

- The patient has no evidence of uncontrolled extrahepatic systemic metastatic disease;
- The lesion(s) treated by radiofrequency are not amenable to open surgical resection or the patient is considered at high risk for adverse outcomes (morbidity and mortality) during open surgical resection; and
- The lesion size is 5 cm or less.

Radiofrequency ablation as a *bridge to transplant* is a medically appropriate treatment option in patients with hepatocellular carcinoma who meet liver transplant criteria and are waiting liver transplantation.

Percutaneous radiofrequency ablation of an osteoid osteoma is a medically appropriate alternative to surgical excision for patients with ALL of the following indications:

- The patient can not be managed successfully with medical management;
- There is sufficient clinical and imaging evidence that tumor is osteoid osteoma; and
- The tumor location allows for safe placement of the radiofrequency catheter (e.g., at least 1 cm away from vascular, neural or other anatomic structures which have the potential for damage,)

Radiofrequency ablation has not been medically proven to be effective in improving clinical outcomes and is considered investigational as a treatment method for other solid tumors, including, but not limited to renal cell carcinoma, breast tumors, pulmonary tumors, and uterine fibroids.

There is no national or local Medicare coverage determination addressing radiofrequency tumor ablation currently.

**Transcatheter Arterial Chemoembolization (TACE)** was developed as an alternative to conventional systemic or intra-arterial chemotherapy. TACE involves insertion of a catheter into the hepatic artery via the femoral artery followed by infusion of cytotoxic drugs, singly or in combinations. Following this, occlusive agents are administered. TACE, as a *bridge to transplant*, is a medically appropriate treatment option in patients with hepatocellular carcinoma who meet liver transplant criteria and are waiting liver transplantation.

TACE remains investigational for all other indications as improvement in the overall survival benefit of this technology remains unproven.

*Upstate Medicare’s Medical Policy #DR001E06, Administration of Chemotherapeutic Agents would provide coverage for TACE: “Intra-arterial administration of chemotherapy (CPT codes 96420-96425) is covered only for the treatment of patients with liver cancer and colon cancer that is metastatic to the liver.”*

**Virtual Colonoscopy** also known as CT colonography, is a non-invasive imaging technique of the colon involving thin-section helical computed tomography (CT) to generate high-resolution 2 and 3-dimensional axial images of the colon. Virtual colonoscopy has not been medically proven to be effective and is currently considered investigational as a method to screen for or diagnose colorectal cancer.

(continued)
However, virtual colonoscopy may be considered a diagnostic option in patients for whom conventional colonoscopy is incomplete due to an inability to pass the colonoscope proximally or if the patient has a concurrent, hazardous medical condition for which conventional colonoscopy is contraindicated.

Upstate Medicare provides coverage for CT colonography only in those patients in whom a fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscope proximally. It is not reimbursable when used for screening or in the absence of signs or symptoms of disease, regardless of family history or other risk factors for the development of colonic disease. It is not reimbursable when used as an alternative to fiberoptic colonoscopy, for screening or in the absence of signs or symptoms of disease.

**CURRENT POLICIES recently updated with minimal changes**

The following policies required only minimal changes (e.g., updating of references, changing language to meet legal needs). **The coverage intent of the policies was not altered.** These policies were recently approved for updating by the Health Plan Medical Directors and are available on our Web site.

- Allogeneic Stem Cell Transplant
- Autologous Stem Cell Transplant
- Brachytherapy or Radioactive Seed Implant for Prostate Cancer
- Electrothermal Collagen Shrinkage for Orthopedic Conditions
- Neuromuscular Electrical Stimulation (combines functional neuromuscular stimulation and therapeutic electrical stimulation)
- Gonadotropin Releasing Hormone Analogues
- Papsure for Cervical Cancer Screening
- Proton Beam Radiation
- Sacral Nerve Stimulation for Pelvic Floor Dysfunction
- Spiral CT for Lung Cancer Screening
- Vagus Nerve Stimulation
- Viscosupplementation of the Knee

**NEW PROTOCOLS recently approved by Corporate Protocol Committee**

There were none this reporting period.

**CURRENT PROTOCOLS recently updated by Corporate Protocol Committee**

There were none this reporting period.
Don’t Forget to Check Out the New Web Enhancements!

As you are probably aware, we introduced new features on our Web site in May. Please be sure to go to www.excellusbcbs.com and check them out!

With the new features, you will be able to:

- Check benefits (for all product lines as you do today on QuickLink).
- Enter, modify and check the status of your referrals for managed care patients (HMO and POS products). For example, primary care physicians (PCPs) may generate referrals to specialists. (Please see the 2005 Medical Management Guidelines to verify which services require a referral.)
- Check the status of prior authorizations for managed care patients (HMO and POS products).
- Enter and check prior authorizations for inpatient urgent/emergent admissions for managed care patients (HMO and POS products). It is extremely important that you continue to call Excellus BlueCross BlueShield to preauthorize all other services that require it (as indicated on the 2005 Prior Authorization Comparison). Please do NOT enter any other service that requires prior authorization into our Web site. We have included a copy of the 2005 Prior Authorization Comparison within this newsletter.

(continued on reverse side)
Don’t forget that you can also:
✓ Check member eligibility (for all product lines as you do today on QuickLink).
✓ View specific claim information
✓ For patients with FourFront or BluePPO HSA-view deductible balance and patient cost sharing information.

If you are not already on the Web, you can register online at www.excellusbcbs.com. If you have any questions, please call the Web Security Help Desk at 1 (800) 278-1247.

If you have questions about how to use these new functions or would like training for you and your office, please contact Provider Service.

Visit us at www.excellusbcbs.com and find out why more than 2,000 offices click with us!
PRIOR AUTHORIZATION REQUIREMENTS COMPARISON – Commercial vs. Safety Net

The following services require prior authorization for either a commercial managed care product or a government safety net product, or both. Please review the column that applies to the member's specific health benefit program.

<table>
<thead>
<tr>
<th>Prior Authorization Requirements</th>
<th>Commercial Managed Care (HMOBlue, BluePoint, BluePoint2) plus Healthy New York HMO*</th>
<th>Government-sponsored Safety Net Programs (HMOBlue Option, Child Health Plus, Family Health Plus - including Monroe Plan members)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>BRCA Testing</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Botox Injections</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Breast Implant Insertion, Removal, Reinsertion (except for breast cancer diagnosis)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Breast Reduction Surgery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Cochlear Device Implant</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>CT Scans</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Dental Treatment Due to Accidental Injury</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Dermabrasion</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Developmental Testing (CHP)</td>
<td>Not required</td>
<td>Required (CHP only)</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Electroconvulsive Therapy (ECT)</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Enbrel administered by Physician</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Enhanced External Counterpulsation (EECP)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Gastric Bypass (Bariatric procedures)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Home Care</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Inpatient Admissions (except emergency &amp; routine maternity) to any facility including hospital, acute rehab, skilled nursing, behavioral health and substance abuse</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>IVIG (intravenous immunoglobulin)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Keloid Scar Revision</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Lesion Removal (other than MD office)</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>LVAD (left ventricular assist device)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>MRA</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>MRI</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Neuropsychological Testing</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Non-Participating Providers</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Otoplasty</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

*Some services, including behavioral health and substance abuse, are not covered benefits under Healthy New York HMO.

**Subject to medical policy/protocol and/or medical necessity review.

Some member contracts may have other restrictions. Not all contracts include all benefits. The provider rendering the service is responsible for ensuring that the required referral or prior authorization has been obtained, as claims will be denied without them.

(continued on next page)
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<th>Government-sponsored Safety Net Programs (HMOBlue Option, Child Health Plus, Family Health Plus), including Monroe Plan members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palatopharyngoplasty</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>PET Scan (Positron Emission Tomography)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Remicade</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Rhinoplasty</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Sclerosing Injection</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Sleep apnea studies</td>
<td>Not required**</td>
<td>Required</td>
</tr>
<tr>
<td>Transplants</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Urinary Incontinence Device</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Vagus Nerve Stimulation</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Vein Ligation</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Viscosupplementation</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Vision Therapy</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Xolair</td>
<td>Not required**</td>
<td>Required</td>
</tr>
</tbody>
</table>

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TETANUS VACCINE RESUBMITTAL

DATE ______________________________

TO:  RTR

FROM:

______________________________

ISSUE: Claims attached are for code 90714, which is a covered service effective 2/1/05.

DO NOT DENY CLAIMS TIMELY FILING LIMIT.

Send claim directly to:
Excellus BlueCross BlueShield
RTR Department
PO Box 4809
Syracuse, NY 13221

July 2005
The Excellus BlueCross BlueShield 2005 Participating Provider Manuals have been loaded to our Web site! Now you can download the entire manual, or choose specific sections.

How do you get to the manuals?

- Go to www.excellusbcbs.com.
- Click For Providers.
- Click on Administration at the top of the page.
- Click on Provider Manuals in the left column.
- The options for the regional manuals will appear under the Provider Manual heading; select the region you need.

If you need a paper copy of the manual:

- Complete the Provider Manual Request Form on the reverse side and fax it to the number indicated on the form.
Provider Manual Request Form

Use this form to request a paper copy of the Excellus BlueCross BlueShield Participating Provider Manual. Please note that the manual is available on the Excellus BlueCross BlueShield Web site at www.excellusbcbs.com.

Number of Manuals to be Shipped (Limit: 3): __________

Provider Name: ____________________________________________

Address: __________________________________________________

Suite Number: ______________________________________________

City, State, Zip+4: __________________________________________

ATTN: _____________________________________________________

Fax this form to: Provider Relations
Excellus BlueCross BlueShield, Utica Region
(315) 731-2530